

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

378

FILED FEB 6 1958

STATE FILE NUMBER

Registration District No.

443

Primary Registration District No.

3007

Registrar's No.

167

1. PLACE OF DEATH

a. COUNTY

Butler

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

MO

b. COUNTY

Butler

b. CITY (If outside corporate limits, give TOWNSHIP only)  
OR TOWN Poplar Bluff

Inside Limits  
Yes ☒ No ☐

c. CITY  
OR TOWN Fisk, MO

0120

Inside Limits  
Yes ☒ No ☐

c. FULL NAME OF (If NOT in hospital, give location)  
HOSPITAL OR INSTITUTION Dr's Hospital

Length of stay in 1b  
1 Day

d. STREET  
ADDRESS

(If outside, give location)

Reside on Farm  
Yes ☐ No ☒

3. NAME OF DECEASED  
(Type or print)

First

Middle

Last

Jesse

Co

Foust

4. DATE  
OF DEATH

Month

Day

Year

Jan

26

1958

5. SEX

M

6. COLOR OR RACE

W

7. MARRIED

NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

1902-12-6

9. AGE (In years)

55-1-20

IF UNDER 1 YEAR  
Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired Farmer

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country)

Arkansas, U.S.

12. CITIZEN OF WHAT COUNTRY?

U.S.

13a. FATHER'S NAME

James W. Foust

13b. MOTHER'S MAIDEN NAME

Caroline Christine

14. NAME OF HUSBAND OR WIFE

Eva Foust

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

42-9-24-2550

17. INFORMANT

Eva Foust

Address

Fisk

MO

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Asphyxiation

INTERVAL BETWEEN  
ONSET AND DEATH

Conditions, if any,  
which gave rise to  
above cause (a),  
stating the under-  
lying cause last

DUE TO (b)

Cardiac Failure

DUE TO (c)

Major Cerebral Vascular Disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

Severe Hypertension

331X

19. WAS AUTOPSY  
PERFORMED?  
YES ☐ NO ☒

20a. ACCIDENT SUICIDE HOMICIDE

☐

☐

☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF  
INJURY

Hour Month, Day, Year  
a.m. p.m.

20d. INJURY OCCURRED  
WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

20e. PLACE OF INJURY (e.g., in or about home,  
farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from 1-25-58 to 1-26-58 and last saw her alive on 1-26-58  
Death occurred at 4:55 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

Dr. Martin S. P. O.

22b. ADDRESS

Poplar Bluff, MO

22c. DATE SIGNED

1/31/58

23a. BURIAL, CREMATION,  
REMOVAL (Specify)

Burial

23b. DATE

Jan 28-58

23c. NAME OF CEMETERY OR CREMATORY

Malden Park Memorial

23d. LOCATION (City, town, or county)

N Malden

(State)

MO

24. FUNERAL DIRECTOR

ADDRESS

Thomas C. Knight Malden MO

25. DATE RECD. BY LOCAL REG.

2/1/58

26. REGISTRAR'S SIGNATURE

R. H. Hume tree

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

RECEIVED

FEB 7 1958

DUTLER CO. HEALTH CENTER

FILE No. \_\_\_\_\_

FEB  
9 1958

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed  
by me, or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*Thomas C. Knight*

Licensed Embalmer No. 2189

P. O. Address Malden MA

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.